MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Mediquip, S.A., L.L.P. P O Box 56082 Houston, Texas 77256	MDR Tracking No.: M4-03-4682-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Ace Insurance Company of Texas 9901 Brodie Lane, Suite 160 PMB 225 Austin, Texas 78748-5612 Box 15	Date of Injury: Employer's Name: HEB Grocery Company, LP Insurance Carrier's No.: 290C918279X

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
08/13/02	08/13/02	E0783	$8,492.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor did not submit a position statement.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier states "Requestor failed to include a statement of medical necessity and a prescription or order for the medical equipment billed in compliance with the DME Ground Rule IX of the 1996 Medical Fee Guideline. Requestor also failed to provide a statement setting out the claimant's diagnosis, prognosis, and expected duration of use of the medical equipment billed in compliance with the DME Ground Rule IX of the 1996 Medical Fee Guideline." EOBs state, "F-Reduction according to medical fee guideline."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider failed to include a statement of medical necessity and a prescription or order for the medical equipment billed in compliance with the DME

Ground Rule IX of the 1996 Medical Fee Guideline. No other denials were noted in the claim file.

Therefore, based on the information provided additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

					Total Left Column:		$0.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled additional reimbursement.

Ordered by:

	Michael Bucklin	02/18/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____